Exhibit A

UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

GARY B. FREEDMAN, ESQUIRE, Administrator of the ESTATE OF ABRAHAM STRIMBER, deceased and BRACHA STRIMBER Plaintiffs, v. STEVEN FISHER, M.D., *et al.* Defendants.	**UNITED STATES DISTRICT COURT EASTERN DISTRICT OF PENNSYLVANIA** No.: 2:13-cv-3145-CDJ

PLAINTIFFS' MOTION TO AMEND COMPLAINT PURSUANT TO F.R.C.P. 15(c) TO ADD RITESH RAMPURE, M.D. AS PARTY DEFENDANT AND TO ASSERT A NEW CLAIM FOR VIOLATION OF 42 U.S.C. §1395dd[1]

Plaintiffs, Gary B. Freedman, Esquire, Administrator of the Estate of Abraham Strimber, deceased, and Brach Strimber, individually, by and through their undersigned counsel hereby files this *Motion to Amend Complaint Pursuant to F.R.C.P. 15(c) to add Ritesh Rampure, M.D. as a Party Defendant and to Assert a New Claim for Violation of 42 U.S.C. §1395dd*, and avers the following in support thereof:

[1] Plaintiffs have attached a copy of their proposed *First Amended Complaint* as Exhibit "A" which contains a Professional Negligence claim (Count X) against Ritesh Rampure, M.D. and claim against Abington Memorial Hospital for a violation of EMTALA (Count XI). Plaintiffs' vicarious liability count (Count VI) was also amended to assert vicarious liability for the negligence of Ritesh Rampure, M.D. Finally, defendants who have since been dismissed *via* stipulation have been removed from the Complaint, including Nurse Practitioner Martinez, for whom a stipulation is currently being prepared and circulated to dismiss.

1. Plaintiffs commenced this medical negligence civil action against various physicians and entities on 6/7/2013 as a result of alleged negligent medical care and treatment rendered to Abraham Strimber on 2/22/2012 at Abington Memorial Hospital. (Rec.Doc. #1).

2. The gravamen of the Complaint is that the defendants failed properly to diagnose Abraham Strimber as suffering from a thoracic aortic dissection/aneurysm, which led to his death at Abington Memorial Hospital shortly after his admission on 2/22/2012. (*Id.*).

A. Joinder of Ritesh Rampure, M.D.

2. On 3/18/2014 during the deposition of Margo Turner, M.D., (hereafter, "Dr. Turner"), who was the internist/hospitalist who admitted Abraham Strimber to Abington Memorial Hospital on 2/22/2012, she testified that she contacted her attending physician, Ritesh Rampure, M.D., to discuss the care of Abraham Strimber. (See Deposition Transcript of Margo Turner, M.D., pg. 62, lines 1-11; pg. 90, lines 6-11; pg. 92, lines 4-15, attached hereto as Exhibit "B").

3. Dr. Turner "presented" the case to Dr. Rampure and discussed her history and physical, symptom, and laboratory studies, such that Dr. Rampure instructed Dr. Turner to cancel a cardiology consult that she had ordered. (*Id.*, pg.92, lines 7-15; pg. 90, lines 17 through pg. 91, lines 1).

4. Prior to the expiration of the applicable statute of limitations and prior to Dr. Turner's deposition, counsel entered into a *Stipulation* which contained a tolling agreement regarding adding Dr. Rampure should he be joined as a defendant after the statute of limitations had expired[2]. (Rec.Doc. #40)

5. The Stipulation tolled the statute of limitations until April 30, 2014. (*Id.*).

[2] The applicable statute of limitations is two (2) years. *See* 42 Pa.C.S.A. 5524(2).

6. Based upon the testimony of Dr. Turner regarding Dr. Rampure's instructions (and/or lack thereof) after presenting Mr. Strimbers' case, Plaintiffs seek to join him as part-defendant at this time.

7. In addition to the foregoing *Stipulation* in which counsel for Dr. Rampure agreed to waive any statute of limitations defense should Dr. Rampure be joined by 4/30/14, Plaintiff also seeks leave of court to join Dr. Rampure pursuant to F.R.C.P. 15(c), which provides in pertinent as follows:

> **"(c) Relation Back of Amendments.**
>
> (1) *When an Amendment Relates Back.* An amendment to a pleading relates back to the date of the original pleading when:
>
> (A) the law that provides the applicable statute of limitations allows relation back;
>
> (B) the amendment asserts a claim or defense that arose out of the conduct, transaction, or occurrence set out - or attempted to be set out – in the original pleading; or
>
> (C) the amendment changes the party or the naming of the party against whom a claim is asserted, if Rule 15(c)(1)(B) is satisfied and if, within the period provided by Rule 4(m) for serving the summons and complaint, the party to be brought in by amendment:
>
> (i) received such notice of the action that it will not be prejudiced in defending on the merits; and
>
> (ii) knew or should have known that the action would have been brought against it, but for a mistake concerning the proper party's identity.

B. Joinder of EMTALA Claim

8. In addition to joining Dr. Rampure as an additional defendant, Plaintiffs seek to amend their Complaint pursuant to F.R.C.P. 15 to assert an additional claim against defendant

Abington Memorial Hospital for a violation of the Emergency Medical Treatment and Active Labor Act, ("EMTALA") 42 U.S.C. §1395dd.

9. The gist of the EMTALA claim is that Abington Memorial Hospital failed properly to screen Mr. Strimber for his presenting complaints in the Emergency Department at Abington Memorial Hospital and failed to stabilize Mr. Strimber for his emergency medical condition. (*See First Amended Complaint* attached hereto as Exhibit "A").

10. Plaintiffs first learned of an alleged EMTALA violation at the time of Dr. Turner's deposition when a document was produced prior to the start of her deposition by counsel for Abington Memorial Hospital evidencing that a standard order set used at the Abington Memorial Hospital Emergency Department required a chest x-ray be given to all patients complaining of chest pain. (*See* Exhibit "C" attached hereto).

11. Decedent Abraham Strimber, despite having complaints of, *inter alia*, chest pain, according to the Emergency Department record, was never given a chest xray or any an imaging of his thorax.

12. In light of the foregoing, Plaintiffs request leave to amend their Complaint to assert a claim against Abington Memorial Hospital for a violation of EMTALA, as such a claim clearly "relates back" as it stems from the same transaction and occurrence giving rise to the existing claims, to wit, the care and treatment of Mr. Strimber in the Emergency Department at Abington Memorial Hospital.

Respectfully submitted,

By: */s/ James E. Hockenberry*
H. Leon Aussprung, III, M.D., Esquire
James E. Hockenberry, Esquire
Counsel for Plaintiffs

UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

GARY B. FREEDMAN, ESQUIRE, Administrator of the ESTATE OF ABRAHAM STRIMBER, deceased and BRACHA STRIMBER Plaintiffs, v. STEVEN FISHER, M.D., *et al.* Defendants.	**UNITED STATES DISTRICT COURT EASTERN DISTRICT OF PENNSYLVANIA** No.: 2:13-cv-3145-CDJ

PLAINTIFFS' BRIEF IN SUPPORT OF THEIR MOTION TO AMEND COMPLAINT PURSUANT TO F.R.C.P. 15(c) TO ADD RITESH RAMPURE, M.D. AS PARTY DEFENDANT AND TO ASSERT A NEW CLAIM FOR VIOLATION OF 42 U.S.C. §1395dd

I. FACTUAL BACKGROUND

Plaintiffs commenced this medical negligence civil action against various physicians and entities on 6/7/2013 as a result of alleged negligence medical care and treatment rendered to Abraham Strimber on 2/22/2012 at Abington Memorial Hospital. (Rec.Doc. #1). The gravamen of the Complaint is that the defendants failed properly to diagnose Abraham Strimber as suffering from a thoracic aortic dissection/aneurysm, which led to his death shortly after his admission on 2/22/2012. (*Id.*).

On 3/18/2014 during the deposition of Margo Turner, M.D., (hereafter, "Dr. Turner"), the internist/hospitalist who admitted Abraham Strimber to Abington Memorial Hospital on

2/22/2012, contacted her attending physician, Ritesh Rampure, M.D., to discuss the care of Abraham Strimber. (See Deposition Transcript of Margo Turner, M.D., pg. 62, lines 1-11; pg. 90, lines 6-11; pg. 92, lines 4-15, attached hereto as Exhibit "B").

According to her testimony, Dr. Turner "presented" the case to Dr. Rampure and discussed her history and physical, the patient's symptoms, and laboratory studies, such that Dr. Rampure instructed Dr. Turner to cancel a cardiology consult that she had ordered. (*Id.*, pg.92, lines 7-15; pg. 90, lines 17 through pg. 91, lines 1). There is absolutely ***no indication in the patient's chart/records from Abington Memorial Hospital that Dr. Rampure treated, consulted on, or offered any medical direction regarding to the care/treatment of Abraham Strimber.*** Had it been known from the records that Dr. Rampure had provided care *via* telephone consultation to Mr. Strimber he would have, undoubtedly, been named as a defendant in this lawsuit.

Prior to the expiration of the applicable statute of limitations and prior to Dr. Turner's deposition, counsel previously entered into a *Stipulation* which contained a tolling agreement regarding adding Dr. Rampure as a defendant in this action after the applicable two (2) year statute of limitations. (Rec.Doc. #40). By agreement of the Dr. Rampure's counsel, they agreed to toll the statute of limitations until April 30, 2014. (*Id.*). Based upon the testimony of Dr. Turner regarding Dr. Rampure's instructions (and/or lack thereof) after presenting Mr. Strimbers' case, Plaintiffs seek to join his as part-defendant at this time.

In this case the applicable statute of limitations for medical negligence claims is two (2) years pursuant to 42 Pa.C.S.A. §5524(2). In addition to the foregoing *Stipulation* in which counsel for Dr. Rampure agreed to waive any statute of limitations defense should Dr. Rampure be joined by 4/30/14, Plaintiff also seek leave of court to joint Dr. Rampure pursuant to F.R.C.P.

15(c), which provides in pertinent as follows:

> **"(c) Relation Back of Amendments.**
>
> (1) *When an Amendment Relates Back.* An amendment to a pleading relates back to the date of the original pleading when:
>
> (A) the law that provides the applicable statute of limitations allows relation back;
>
> (B) the amendment asserts a claim or defense that arose out of the conduct, transaction, or occurrence set out - or attempted to be set out – in the original pleading; or
>
> (C) the amendment changes the party or the naming of the party against whom a claim is asserted, if Rule 15(c)(1)(B) is satisfied and if, within the period provided by Rule 4(m) for serving the summons and complaint, the party to be brought in by amendment:
>
> (i) received such notice of the action that it will not be prejudiced in defending on the merits; and
>
> (ii) knew or should have known that the action would have been brought against it, but for a mistake concerning the proper party's identity.

In addition to joining Dr. Rampure as an additional defendant, Plaintiffs seek to amend their Complaint pursuant to F.R.C.P. 15 to assert an additional claim against defendant Abington Memorial Hospital for a violation of the Emergency Medical Treatment and Active Labor Act, ("EMTALA") 42 U.S.C. §1395dd. The gist of the EMTALA claim is that Abington Memorial Hospital failed properly to screen Mr. Strimber for his presenting complaints in the Emergency Department at Abington Memorial Hospital and failed to stabilize Mr. Strimber for his emergency medical condition. (*See First Amended Complaint* attached hereto as Exhibit "A").

Plaintiffs first learned of an alleged EMTALA violation at the time of Dr. Turner's deposition when a document was produced prior to the start of her deposition by counsel for Abington Memorial Hospital evidencing that a standard order set used at the Abington Memorial

Hospital Emergency Department required a chest xray be given to all patients complaining of chest pain. (*See* Exhibit "C" attached hereto). Decedent Abraham Strimber, despite having complaints of, *inter alia,* chest pain, according to the Emergency Department record, was never given a chest xray or any an imaging of his thorax/chest.

II. LEGAL STANDARD

Pursuant to Rule 15(a), a party may amend its pleading with the other party's consent or with leave of court, which the court "shall freely give when justice so requires." Amendments to a complaint pursuant to Rule 15 are "liberally granted" and "rest within the sound discretion of the trial court." *Massarsky v. Gen. Motors Corp.*, 706F.2d 111, 125(3d Cir.1983); see also *Adams v. Gould, Inc.*, 739 F.2d 858, 864 (3d Cir. 1984) ("[T]he district court's discretion to deny Leave to amend 'is limited by the "liberal amendment philosophy"of the Federal Rules of Civil Procedure.). The court should grant leave in the absence of undue delay, bad faith, undue Prejudice to the opposing party, or futility of the amendment. *See Adams*, 739 F.2d at 864 (citing Foman v. Davis, 371U.S. 178(1962)); *see also Lorenz v. CSX Corp.*, 1 F.3d 1406, 1414 (3d Cir.1993) (citing Cornell &Co. v. Occupational Safety &Health Review Comm'n, 573 F.2d 820, 833 (3d Cir. 1978). "Futility" means that the "complaint, as amended, would fail to state a claim upon which relief could be granted.'" *Shane v. Fauver*, 213 F.3d 113, 115 (3d Cir. 2000).

"The liberal tenor of Rule 15 is reinforced by the often-recognized principle that the Federal Rules of Civil Procedure are to be liberally construed so as to effectuate the underlying goal that cases be tried on the merits wherever possible." *Johnson v. Goldstein*, 850 F. Supp. 327, 329 (E.D. Pa. 1994).

1. Amendment to Join Ritesh Rampure, M.D.

As noted above, Plaintiffs and counsel for Dr. Rampure entered into a stipulation in

which Dr. Rampure would not assert a defense of statute of limitations should he be joined as a defendant on or before 4/30/14 in consideration for not joining him as a defendant at that time, *i.e.*, previously, and to determine if he should be added following additional discovery. (Red. Doc. #40). Thus, there is not prejudice, surprise, or undue delay in adding Dr. Rampure. In addition, there is approximately one (1) month left of discovery in which to schedule any deposition of Dr. Rampure.

Moreover, notwithstanding the *Stipulation* regarding Dr. Rampure, Plaintiffs may properly add Dr. Rampure as an additional defendant to the action if they satisfy the requirements of Federal Rules of Civil Procedure 15(c)(2) and 15(c)(3). An amendment of a pleading relates back to the date of the original pleading when:

> (2) the claim or defense asserted in the amended pleading arose out of the conduct, transaction, or occurrence set forth or attempted to be set forth in the original pleading, or
>
> (3) the amendment changes the party or the naming of the party against whom a claim is asserted if the foregoing provision (2) is satisfied **and**, within the period provided by Rule 4(m) for service of the summons and complaint, the party to be brought in by amendment (A) has received such notice of the institution of the action that the party will not be prejudiced in maintaining a defense on the merits, **and** (B) knew or should have known that, but for a mistake concerning the identity of the proper party, the action would have been brought against the party.

Fed.R.Civ.P. 15(c).

Plaintiffs address these requirements *seriatim*. In this case, it is clear that the claim against Dr. Rampure "arose out of the same conduct, transaction, or occurrence" that has been set forth in the original complaint. In fact, the Count X in Plaintiffs' proposed *First Amended Complaint* is virtually identical to the claim made against Dr. Turner regarding the care and treatment rendered to Dr. Rampure. (*See* Exhibit "A" attached hereto). The next requirement is

that Dr. Rampure was required to have received notice of the institution of this action within 120 days (per Rule 4(m)). In this case, the statute of limitations did not expire until **2/22/2014** and the time period under Rule 4(m) would allow Plaintiffs up to and including **6/22/2014** in which to serve the Complaint and Summons. Clearly Dr. Rampure had notice of this lawsuit and the claim as he signed an Affidavit on **2/19/2014** immediately before the expiration of the statute of limitations. (*See* Exhibit "C" attached hereto).

With regard to the last element, Dr. Rampure knew, or should have known, as evidenced in part by his *Affidavit* and counsel's subsequent *Stipulation* based upon the same (Rec. Doc. #40) that had his identity been known from the medical records as well as his role in caring for Mr. Strimber, *i.e.* that Mr. Strimber's case had been presented to him in detail and that he gave direction on the medical management of Mr. Strimber, he would have been joined as a defendant. Lastly, it is important to put out that it is judicially efficient to permit Plaintiffs to joint Dr. Rampure in this litigation in light of the *Stipulation* as Plaintiffs would otherwise be forced to commence a new action against Dr. Rampure, either in state or federal court, and then consolidate these actions together.

2. Amendment to Assert an EMTALA Claim

With regard to Plaintiffs' request to amend their complaint to add an EMTALA claim, the analysis is simpler: the question is whether "the amendment asserts a claim. . .that arose out of the conduct, transaction, or occurrence set out. . .in the original pleading;" *See* F.R.C.P. 15(c)(1)(B). The test for relation back is stated in the disjunctive: a claim arising from either the same conduct, **or** the same transaction, **or** the same occurrence as the claim set forth (or attempted to be set forth) in the original pleading. *Federal Deposit Ins. Corp. v. Bennett*, 898 F.2d 477, 479 (CA5 1990).

The United State Supreme Court has held that these terms' usual meanings were to be given literal application. *Tiller v. AtlanticCoast Line R.R. Co.*, 323 U.S. 574 (1945). The *Tiller* court held that a claim will relate back when the original complaint alleges an injury and the claim in the amended complaint alleges additional causes of that same injury. *Id.* at 581. This is exactly the case here: the amended complaint sets forth an additional cause of the same injury, *i.e.*, the death of Abraham Strimber. Rather than mere professional negligence, Plaintiffs' *First Amended Complaint* avers that the injuries were also caused by defendant Abington Memorial Hospital's violation of EMTALA.

III. CONCLUSION

Plaintiffs *Motion to Amend* with regard to Dr. Rampure should be granted in light of the *Stipulation* between counsel, and as well as for judicial efficiency to avoid the filing of a separate lawsuit followed by consolidation. Furthermore, joining Dr. Rampure as a party is permissible pursuant to F.R.C.P. 15(c). Lastly, Plaintiffs' *Motion to Amend* should be granted with regard to the EMTALA claim as it (1) clearly arises from the same transaction or occurrence; (2) there was no undue delay in bringing the claim as Plaintiffs only recently became aware of facts sufficient to support such a claim; (3) there is no prejudice to the defendant; and (4) it is not futile.

Respectfully submitted,

By: */s/ James E. Hockenberry*
H. Leon Aussprung, III, M.D., Esquire
James E. Hockenberry, Esquire
Counsel for Plaintiffs

UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

GARY B. FREEDMAN, ESQUIRE, Administrator of the ESTATE OF ABRAHAM STRIMBER, deceased and BRACHA STRIMBER Plaintiffs, v. STEVEN FISHER, M.D., *et al.* Defendants.	**UNITED STATES DISTRICT COURT EASTERN DISTRICT OF PENNSYLVANIA** No.: 2:13-cv-3145-CDJ

ORDER GRANTING PLAINTIFFS' MOTION TO AMEND

AND NOW, this ___ day of _____, 2014, upon consideration of *Plaintiffs' Motion to Amend* and any response thereto, it is hereby ORDERED, DIRECTED, and DECREED that said *Motion* is GRANTED. Plaintiffs may file their *First Amended Complaint* attached to their foregoing motion within ___ days of the date of this Order.

BY THE COURT:

_____
J. WILLIAM DITTER, JR
U.S. DISTRICT COURT JUDGE

Exhibit B

Abington Memorial Hospital	Department Manual: EMERGENCY TRAUMA CENTER	Policy Number: ETC
Title: Myocardial Infarction – Primary Percutaneous Coronary Intervention for Acute ST Segment Elevation/New Left Bundle Branch Block Myocardial Infarction	**Category:** **Patient Care**	**Original Date:** 2/98
Policy Owner: ETC Director	**Keywords: MI and PCI**	**Last Review Date:** 5/07
Referenced With: [Type Here]	**Review Cycle:** Annual	**Last Revision Date:** 5/09

I. **PURPOSE:** To provide guidelines for the identification, evaluation, and management of patients who present with chest discomfort or symptoms suggestive of ischemic coronary artery disease (CAD) and are found to have acute ST segment elevation or new left bundle branch block (LBBB) consistent with acute myocardial infarction (AMI).

II. **PROCEDURE:**

A. All patients presenting to the Emergency Trauma Center with chest pain or other symptoms suggestive of acute cardiac ischemia will undergo a prompt evaluation. This evaluation will include the following:

1. A twelve lead electrocardiogram (ECG) will be performed as soon as possible after arrival

2. The nurse or clinical associate who performs the test will present the ECG directly to the responsible emergency physician for interpretation

3. If the emergency physician interprets the ECG as demonstrating an acute ST elevation/new LBBB myocardial infarction, he/she will notify the Interventional Cardiologist (IC) immediately

4. The ETC physician will perform a targeted history and physical to determine:
   - if an AMI is likely
   - if the patient has any contra-indications to PCI
   - whether the patient has a current cardiologist

5. After this evaluation, the ETC physician will then activate a Percutaneous Coronary Intervention (PCI) Alert and notify the patient's primary nurse immediately

6. If the ETC physician is uncertain if the patient is a candidate for PCI, he/she will discuss the management with the IC prior to activating a PCI Alert

B. Activation of PCI Alert

1. The ETC physician will notify the primary ETC nurse and the ETC Administrative Associate (AA)

2. The ETC AA will contact the IC as follows:
   - Abington Medical Specialists – Cardiology (AMS Cardiology)
     - 8:00 am – 5:00 pm (M - F except holidays) contact the office at x4075

- All other times and when there is no response at x4075, call the IC on call by contacting the AMS Cardiology answering service.
- Pennsylvania Heart and Vascular (PHV)
  - 8:00 am – 5:00 pm (M - F except holidays) and weekday nights, page Dr. Frechie. If no rapid response, AMS Cardiology should be contacted as above.

3. The ETC AA will activate a PCI Alert.
   - During normal catheterization laboratory working hours (M – F except holidays, 7:00 am – 5:00 pm) the AA will call 2437 to activate a PCI Alert
   - All other times, the AA will contact the hospital operator at 777 to activate a PCI Alert

4. The hospital operator will contact the members of the PCI Alert team after hours
   - Calls will be placed to:
     - Catheterization laboratory on-call team
     - CCU nurse manager (x2140)
     - Hospital Nursing Coordinator (x7103)
     - Bed Coordinator (x7980)
   - If no response by the catheterization team, the operator will contact the catheterization laboratory to determine if the team is already present

C. Roles/Responsibilities

1. Interventional Cardiologist
   - Will immediately respond to ETC to discuss patient with ETC physician
   - During off hours, if the IC is aware that the catheterization team is in the hospital, he should inform the catheterization laboratory to prepare
   - Facilitate rapid movement of the patient to the catheterization laboratory

2. ETC Physician
   - Interpret all ECG's as soon as possible after patient arrival
   - Perform rapid assessment to determine if Primary PCI is indicated
   - Initiate PCI Alert as above
   - Initiate medical management/stabilization of patient
   - Document interventions in the clinical record

3. ETC Primary Nurse
   - Ensure that ECG is performed and presented to the ETC physician as soon as possible after patient arrival
   - Activate PCI Alert packet
     - PCI Alert Tool
     - Consent Form
     - R2 pads
   - Initiate medical management/stabilization in a timely manner. This may include:
     - Administration of aspirin
     - Administration of beta-blocker
     - Administration of heparin
   - Prepare the patient for transfer to the catheterization laboratory with assistance from a secondary ETC nurse and/or CCU nurse:
     - Apply R2 pads if available
     - Bifurcate intravenous lines

  - Prepare inguinal area for procedure with use of clippers
  - Place patient on transport monitor
- Document times of each communication point on the PCI Alert Tool which will be used for performance assessment purposes only and not part of the permanent record
- Complete documentation of all interventions on the clinical record
- Assist catheterization team in the laboratory with patient preparation and treatment

4. CCU Nurse
   - Respond immediately to PCI Alert with appropriate equipment
   - Assist ETC nurse in stabilization and transport of patient to the catheterization laboratory
   - Assist catheterization team in the laboratory with patient preparation and treatment

5. Catheterization Laboratory Team
   - Immediately prepare room during weekday working hours
   - Repond to PCI Alert immediately and report to catheterization laboratory as soon as possible during on-call hours
   - Contact ETC Primary nurse when first catheterization team member arrives to facilitate patient movement to the laboratory

6. Nursing Coordinator
   - Respond to PCI Alert immediately
   - Open catheterization laboratory and prepare room for incoming cathetherization team members during on-call hours
   - Assist catheterization team, ETC nurse, and CCU nurse in the care of the patient until the full catheterization team arrives

7. Hospital Operator
   - Immediately call PCI Alert as above
   - Contact the ETC AA to inform them that the catheterization laboratory on-call team, nursing coordinator, and CCU have been notified

8. ETC AA
   - Assist ETC physician with the initiation of the PCI Alert and contacting the IC
   - Inform ETC physician and primary nurse that the team has responded
   - Direct the IC to the ETC physician
   - Document times of all calls/pages and response times in ED Pulsecheck and communicate this information to the primary nurse for documentation on the PCI Alert Tool
   - Confirm bed assignment with the bed coordinator/nursing supervisor
   - Contact appropriate resident

9. Bed Coordinator
   - Assign an intensive care unit bed for the patient as soon as possible
   - Communicate this bed assignment to the ETC AA and the catheterization team

PP099.02
Written 2/98

Reviewed March 1999, February 2000

Revised March 2002

Myocardial Infarction.04

Revised 4/04, 11/04

Revised 5/07

Revised 5/09

Exhibit C

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

- - -

GARY B. FREEDMAN, ESQUIRE, Administrator of the ESTATE OF ABRAHAM STRIMBER, deceased and BRACHA STRIMBER,	:	NO. 2:13-cv-3145-CDJ
Plaintiffs,	:	
v.	:	
STEVEN FISHER, M.D., et al.,	:	
Defendants.	:	

- - -

Thursday, September 25, 2014

- - -

Videotape deposition of MICHAEL E. CHANSKY, M.D., taken pursuant to notice, was held at the law offices of Christie Pabarue and Young, 1880 JFK Boulevard, 10th Floor, Philadelphia, Pennsylvania, commencing at 2:00 p.m., on the above date, before Amy M. Murphy, a Professional Court Reporter and Notary Public there being present.

- - -

an appropriate medical screening examination for them?
A. I agree with that, yes.
Q. Okay. And do you agree with me that -- well, you mentioned you reviewed a couple policies and procedures. There was a policy on EMTALA that Abington Hospital had, correct?
A. Yes.
Q. I'm going to mark that as Exhibit-8.

- - -

(Whereupon, Exhibit-8 was marked for identification.)

- - -

BY MR. AUSSPRUNG:
Q. This is what you were referring to?
A. Yes.
Q. Now, does this policy, in any way, explain what an appropriate medical screening examination consists of?
A. Yes. It consists of the

triage nurse assessment. And then the attending physician performs a medical screening exam, which, based on their determination, which is a history and physical, they're provided stabilization and treatment from there.
Q. And that is what -- that is the medical screening examination that is required for every patient in the Abington Memorial Hospital emergency department, correct?
A. Yes.
Q. Are different types of medical screening examinations required for different types of patients?
MR. YOUNG: I'm going to object to the form of the question.
MR. AUSSPRUNG: Let me ask it a different way.
BY MR. AUSSPRUNG:
Q. Is the required medical screening examination for a patient who presents with diaphoresis and chest pain

different than for the patient that presents with pain in his ankle?
A. Yes.
Q. So then the appropriate medical screening examination that is required is based upon the presentation of the patient, correct?
A. Yes.
Q. So does this EMTALA policy marked as Exhibit-8 explain, in any way, what the appropriate medical screening exam is for any particular group or category of patients?
A. No.
Q. There was a second policy and procedure. I'll cover it now just because it seems like a logical direction to go even though it's a little off course. I'm going to mark it as Exhibit-9.

- - -

(Whereupon, Exhibit-9 was marked for identification.)

- - -

BY MR. AUSSPRUNG:
Q. In your supplemental report you mentioned you also reviewed this policy of Abington Memorial Hospital. It's entitled Myocardial Infarction?
A. Yes.
Q. Now, this policy, I'll just read the purpose paragraph. It says it only applies for patients with certain criteria who also were found to have acute ST segment elevation, correct?
A. Yes.
Q. So did this policy apply to Mr. Strimber?
A. It did up into the point of the EKG being shown to a doctor and a decision made that he did not have an ST segment elevation MI or a new left bundle branch block.
Q. You are a slow methodical speaker, and I don't want to interrupt you. But I do tend to go a little faster than you, so I apologize in advance if I interrupt you and step on you. If you're

Exhibit D

Abington Memorial Hospital

History & Physical

Summary 02/22/2012 00:00 through 02/22/2012 23:59

HP

Permanent Chart Copy

DCOBY	**STRIMBER, ABRAHAM**		MM__
MR#: 0482935	FIN#: 1205350964	DOB: 11/14/1950	AdmitDate: 02/22/2012
DR: Watson, Robert		Age: 61y	Service: Observation

History & Physical

*** This Document Has Been Modified ***

Originally Created:2/22/2012 4:09:00 PM
By: Turner, Margo (MD)

SERVICES:

- Div/Dept — Internal Medicine

CHIEF COMPLAINT:

.:

Chief Complaint: chest / epigastric / back pain , n/v/d
History Source: patient, spouse

HISTORY OF PRESENT ILLNESS:

.:

HPI: Patient is a 61 year old man who is s/p valve replacement surgery (avr & ?? mvr) who presents to ER for e/o legs vibrating and abdomen feeling like it is going to explode. Pt reports that abdominal pain is mid epigastric, pt had one episode of diarrhea yesterday and has vomited once in ER.
Pt describes eating radishes, tomatoes , eggs and lox today and feeling these symptoms after that.
Pt had non contrast ct abd in ER and is admitted for further evaluation and management.

MEDICATIONS TAKEN AT HOME (entered in Sunrise Med Rec):

Warfarin.., mg, PO, DAILY (2100); patient dose varies between 5 and 7.5 mg daily depending on inr results , 22-Feb-2012, Historical
Metoprolol, (, LOPRESSOR) Tablet\par 12.5 mg, ORAL, DAILY, 22-Feb-2012, Historical
Multivitamin Therapeutic, Tablet\par 1 tablet(s), ORAL, DAILY, 22-Feb-2012, Historical

ALLERGIES:

- Iodinated contrast: Z_Anaphylaxis
- Iodinated radiocontrast dyes: Undefined
- IVP dye: Undefined
- Iodinated radiocontrast agents: Z_Entered brand

REVIEW OF SYSTEMS:

Comments:

.: All other system are noncontributory.

PHYSICAL EXAM TEXT:

Physical Exam Text:

Physicial Exam Text: vs : bp 131/59 p 70 r 18
heart : s 1 & s 2 in rr
lungs : bs + both lung fields
abd : nabs, soft, non tender, no cvat

DCOBV STRIMBER, ABRAHAM MM

MR#: 0482935 FIN#: 1205350964 DOB: 11/14/1950 AdmitDate: 02/22/2012

DR: Watson, Robert Age: 61y Service: Observation

ext : no e / no p
neuro : non focal examination

LAB RESULTS:

22-Feb-2012 12:37

PTT	40
Glucose (Random)	141
BUN	14
Creatinine	1.32
Sodium Level	141
Potassium	3.7
Chloride	105
Carbon Dioxide	23
Anion Gap	17
AST	26
ALT	18
Alkaline Phosphatase	68
Calcium Level	8.9
Albumin	4.3
Total Protein	6.6
Calculated GFR	55
GFR African American	>60
Bilirubin,Total	0.5
CK w/Reflexive MB	161
INR	2.8
WBC	12.1
RBC	5.02
Hemoglobin	15.0
Hematocrit	43.8
Platelets	192
MCV	87.4
MCH	29.9
MCHC	34.2
RDW	12.7

MPV	8.1
Neutrophils	80
Lymphs	11
Monocytes	8
EOS.	1
Basos	0
Absolute Neutro	9.7
Absolute Mono.	1.0
Absolute EO	0.1
Absolute Baso.	0.0
Absolute Lymph.	1.3

OTHER RESULTS:

Radiology Results:

Cat Scan:

22-Feb-2012 12:57, CT ABD/Pelvis W-O Contrast

CT ABD/Pelvis W-O Contrast: FINALCT ABD PEL W O CONTRASTHISTORY: Mid upper abdominal and back pain. TECHNIQUE: Helical axial images were obtained from the domes of the diaphragm through the pubic symphysis. Neither oral nor intravenous contrast was administered.Coronal and sagittal reformatted images were also evaluated. Comparison: None. FINDINGS: The patient is status post median sternotomy. The heart is enlarged. There is no pericardial effusion. There is dependent atelectasis at the lung bases posteriorly. Evaluation of the abdominal and pelvic organs is limited without intravenous contrast. The liver is unremarkable without evidence of solid mass or biliary ductal dilatation. The gallbladder is unremarkable in appearance. The spleen isnormal in appearance. The pancreas is unremarkable. The right adrenal gland is unremarkable. There is a subcentimeter low-attenuation nodule in the left adrenal gland which likely represents an adenoma. There are no abnormally enlarged mesenteric, retroperitoneal, pelvic, or inguinal lymph nodes. There is a small fat containing left inguinal hernia. The prostate gland is unremarkable. The urinary bladder is normal in appearance without focal mass or wall thickening. There is no bowel obstruction, bowel wall thickening, or free air. No free fluid is visualized. A normal appendix is visualized. No hydronephrosis or renal calculus is seen. There is a cystic lesion in the lower pole the left kidney, which is likely a simple cyst, however isincomplete characterized on this noncontrast examination. Repeat study with intravenous contrast and be helpful to better characterize the nature of this lesion. There is minimal aortoiliac atherosclerosis. There is no aneurysmal dilatation or evidence of dissection or rupture on this noncontrast study. There are mild scoliotic and degenerative changes of the spine. No destructive bony lesions are visualized. Impression: Somewhat limited study without intravenous contrast. Cystic lesion

Abington Memorial Hospital

History & Physical

Summary 02/22/2012 00:00 **through** 02/22/2012 23:59

HP

Permanent Chart Copy

DCOBV	STRIMBER, ABRAHAM		MM__
MR#: 0482935	FIN#: 1205350964	DOB: 11/14/1950	AdmitDate: 02/22/2012
DR: Watson, Robert		Age: 61y	Service: Observation

in the left kidney is likely a simple cyst , however it is incompletely characterized without intravenous contrast. Ultrasound of the kidneys or CT scan with intravenous contrast would be helpful to better determine the nature of this lesion. No abdominal aortic aneurysm. No evidence of dissection on this noncontrast study. Cardiomegaly. Signed by: GOLDMAN, YEDIDA Signed on: 02/22/2012 13:31:31

PLAN COMMENTS:

.:

Comments (Assessment and Plan): 1) chest / epigastric / back pain - nc ct abd done, telemetry, trend ce, ekg , anti emetics and analgesics
2) history of valve replacement surgery - inr 2.8, coumadin on hold as pt is npo - await further recommendations
3) n/v/d - npo, ivf, stool culture & stool for c. diff
Meds and plans as per orders.

Electronic Signatures:

Turner, Margo (MD) (Signed 22-Feb-2012 20:20)

Entered: SERVICES, CHIEF COMPLAINT, HISTORY OF PRESENT ILLNESS, MEDICATIONS TAKEN AT HOME (entered in Sunrise Med Rec), OMP, ALLERGIES, REVIEW OF SYSTEMS, PHYSICAL EXAM TEXT, LAB RESULTS, OTHER RESULTS, ASSESSMENT & PLAN, PLAN COMMENTS,
Authored: SERVICES, CHIEF COMPLAINT, HISTORY OF PRESENT ILLNESS, MEDICATIONS TAKEN AT HOME (entered in Sunrise Med Rec), OMP, ALLERGIES, REVIEW OF SYSTEMS, PHYSICAL EXAM TEXT, LAB RESULTS, OTHER RESULTS, ASSESSMENT & PLAN, PLAN COMMENTS
Last Updated: 22-Feb-2012 20:20

Edit History

HPI

Patient is a 61 year old man who is s/p valve replacement surgery (avr & ?? mvr) who presents to ER for c/o legs vibrating and abdomen feels like it is going to explode. Pt reports that abdominal pain is mid epigastric, pt had one episode of diarrhea yesterday and has vomited once in ER.
Pt describes eating radishes, tomatoes , eggs and lox [Originally Entered by: Turner, Margo (MD) on: 2/22/2012 4:28:30 PM]
Patient is a 61 year old man who is s/p valve replacement surgery (avr & ?? mvr) who presents to ER for c/o legs vibrating and abdomen feeling like it is going to explode. Pt reports that abdominal pain is mid epigastric, pt had one episode of diarrhea yesterday and has vomited once in ER.
Pt describes eating radishes, tomatoes , eggs and lox today and feeling these symptoms after that.
Pt had non contrast ct abd in ER and is admitted for further evaluation and management. [Changed to this value by: Turner, Margo (MD) on: 2/22/2012 8:20:12 PM]

Abington Memorial Hospital

History & Physical

Summary 02/22/2012 00:00 through 02/22/2012 23:59

HP

Permanent Chart Copy

DCOBV	STRIMBER, ABRAHAM		MM__
MR#: 0482935	FIN#: 1205350964	DOB: 11/14/1950	AdmitDate: 02/22/2012
DR: Watson, Robert		Age: 61y	Service: Observation

Medications taken at home (entered in Sunrise Med

Warfarin.., mg, PO, DAILY (2100); patient dose varies between 5 and 7.5 mg daily depending on inr results, 22-Feb-2012, Historical [Selected by: Turner, Margo on: 2/22/2012 4:15:46 PM]

Metoprolol, (. LOPRESSOR) Tablet12.5 mg, ORAL, DAILY, 22-Feb-2012, Historical [Selected by: Turner, Margo on: 2/22/2012 4:15:46 PM]

Multivitamin Therapeutic, Tablet1 tablet(s), ORAL, DAILY, 22-Feb-2012, Historical [Selected by: Turner, Margo on: 2/22/2012 4:15:46 PM]

ALLERGIES

Iodinated contrast, Z_Anaphylaxis [Selected by: Turner, Margo on: 2/22/2012 4:15:46 PM]

iodinated radiocontrast dyes, Undefined [Selected by: Turner, Margo on: 2/22/2012 4:15:46 PM]

IVP dye, Undefined [Selected by: Turner, Margo on: 2/22/2012 4:15:46 PM]

Iodinated radiocontrast agents, Z_Entered brand [Selected by: Turner, Margo on: 2/22/2012 4:15:46 PM]

Abington Memorial Hospital

History & Physical

Summary 02/22/2012 00:00 through 02/22/2012 23:59

HP

Permanent Chart Copy

DCOBV **STRIMBER, ABRAHAM** MM__

MR#: 0482935 FIN#: 1205350964 DOB: 11/14/1950 AdmitDate: 02/22/2012

DR: Watson, Robert Age: 61y Service: Observation

LAB RESULTS

22-Feb-2012 12:37

PTT. 40
Glucose (Random) 141
BUN 14
Creatinine 1.32
Sodium Level 141
Potassium 3.7
Chloride 105
Carbon Dioxide 23
Anion Gap 17
AST 26
ALT 18
Alkaline Phosphatase 68
Calcium Level 8.9
Albumin 4.3
Total Protein 6.6
Calculated GFR 55
GFR African American >60
Bilirubin,Total 0.5
CK w/Reflexive MB 161
INR 2.8
WBC 12.1
RBC 5.02
Hemoglobin. 15.0
Hematocrit 43.8
Platelets 192
MCV 87.4
MCH 29.9
MCHC 34.2
RDW 12.7
MPV 8.1
Neutrophils 80
Lymphs 11
Monocytes 8
EOS. 1
Basos 0
Absolute Neutro 9.7
Absolute Mono. 1.0
Absolute EO 0.1
Absolute Baso. 0.0
Absolute Lymph. 1.3

[Selected by: Turner, Margo on: 2/22/2012 4:15:46 PM]

Abington Memorial Hospital

History & Physical

Summary 02/22/2012 00:00 through 02/22/2012 23:59

HP

Permanent Chart Copy

DCOBV	**STRIMBER, ABRAHAM**		MM__
MR#: 0482935	FIN#: 1205350964	DOB: 11/14/1950	AdmitDate: 02/22/2012
DR: Watson, Robert		Age: 61y	Service: Observation

Radiology Results

CT ABD/Pelvis W-O Contrast, U, FINALCT ABD PEL W O CONTRASTHISTORY: Mid upper abdominal and back pain. TECHNIQUE: Helical axial images were obtained from the domes of the diaphragm through the pubic symphysis. Neither oral nor intravenous contrast was administered.Coronal and sagittal reformatted images were also evaluated. Comparison: None. FINDINGS: The patient is status post median sternotomy. The heart is enlarged. There is no pericardial effusion. There is dependent atelectasis at the lung bases posteriorly. Evaluation of the abdominal and pelvic organs is limited without intravenous contrast. The liver is unremarkable without evidence of solid mass or biliary ductal dilatation. The gallbladder is unremarkable in appearance. The spleen isnormal in appearance. The pancreas is unremarkable. The right adrenal gland is unremarkable. There is a subcentimeter low-attenuation nodule in the left adrenal gland which likely represents an adenoma. There are no abnormally enlarged mesenteric, retroperitoneal, pelvic, or inguinal lymph nodes. There is a small fat containing left inguinal hernia. The prostate gland is unremarkable. The urinary bladder is normal in appearance without focal mass or wall thickening. There is no bowel obstruction, bowel wall thickening, or free air. No free fluid is visualized. A normal appendix is visualized. No hydronephrosis or renal calculus is seen. There is a cystic lesion in the lower pole the left kidney, which is likely a simple cyst, however isincomplete characterized on this noncontrast examination. Repeat study with intravenous contrast and be helpful to better characterize the nature of this lesion. There is minimal aortoiliac atherosclerosis. There is no aneurysmal dilatation or evidence of dissection or rupture on this noncontrast study. There are mild scoliotic and degenerative changes of the spine. No destructive bony lesions are visualized. Impression: Somewhat limited study without intravenous contrast. Cystic lesion in the left kidney is likely a simple cyst , however it is incompletely characterized without intravenous contrast. Ultrasound of the kidneys or CT scan with intravenous contrast would be helpful to better determine the nature of this lesion. No abdominal aortic aneurysm. No evidence of dissection on this noncontrast study. Cardiomegaly. Signed by: GOLDMAN, YEDIDA Signed on: 02/22/2012 13:31:31 [Selected by: Turner, Margo on: 2/22/2012 4:15:46 PM]

Comments (Assessment and Plan)

1) chest / epigastric / back pain - nc ct abd done, telemetry, trend ce, ekg , consult Cardiology, anit emetics and analgesics
2) history of valve replacement surgery - inr 2.8, coumadin on hold as pt is npo - await Cardiology recommendations
3) n/v/d - nop, ivf, stool culture
Meds and plans as per orders. [Originally Entered by: Turner, Margo (MD) on: 2/22/2012 4:15:46 PM]
1) chest / epigastric / back pain - nc ct abd done, telemetry, trend ce, ekg , anti emetics and analgesics
2) history of valve replacement surgery - inr 2.8, coumadin on hold as pt is npo - await further recommendations
3) n/v/d - npo, ivf, stool culture & stool for c. diff
Meds and plans as per orders. [Changed to this value by: Turner, Margo (MD) on: 2/22/2012 8:20:12 PM]

Last Updated / Modified 02/22/2012 20:20:12
Turner, Margo (MD)

ABINGTON MEMORIAL HOSPITAL
EMERGENCY DEPARTMENT

Strimber, Abraham
DOB: 11/14/1950 M61
Wt/Ht:
MedRec: 0482935
AcctNum: 1205350964

Patient Data

Complaint: CHEST PAIN
Triage Time: Wed Feb 22, 2012 11:45
Urgency: ESI Level 2
Bed: ED ETC5
Initial Vital Signs: 2/22/2012 11:42
BP:169/84
P:66
O2 sat:

ED Attending: Fisher, MD, Steven
Primary RN: Stebulis, RN, Lynne

R:18
T:96.1 (PO)
Pain:

TRIAGE (Wed Feb 22, 2012 11:45 LS)
PATIENT: NAME: Strimber, Abraham, AGE: 61, GENDER: male, DOB: Tue Nov 14, 1950, TIME OF GREET: Wed Feb 22, 2012 11:40, MEDICAL RECORD NUMBER: 0482935, ACCOUNT NUMBER: 1205350964. (Wed Feb 22, 2012 11:45 LS)
ADMISSION: URGENCY: ESI Level 2, BED: UNASSIGN. (Wed Feb 22, 2012 11:45 LS)
VITAL SIGNS: BP 169/84, Pulse 66, Resp 18, Temp 96.1, (PO), Time 2/22/2012 11:42. (11:42 LS)
COMPLAINT: CHEST PAIN. (Wed Feb 22, 2012 11:45 LS)
ASSESSMENT: **pt here w/ c/o legs vibrating and abd feels like is going to explode. pt denies chest pain. pt states he had 1 episode of loose stools today after eating radishes, tomatoes, eggs and locs. pt also had centrum vitamin. pt w/ multiple complaints.** (Wed Feb 22, 2012 11:45 LS)
GCS: Total GCS score is 15: eye opening (4), verbal response (5), motor response (6). (Wed Feb 22, 2012 11:45 LS)
PROVIDERS: TRIAGE NURSE: Lori Ischinger, RN. (Wed Feb 22, 2012 11:45 LS)
PREVIOUS VISIT ALLERGIES: Iodinated contrast -- Anaphylaxis, Iodinated radiocontrast dyes, Ivp dye. (Wed Feb 22, 2012 11:45 LS)

HPI (17:15 SF)
HPI TRANSCRIPTION: The patient is a 61-year-old gentleman with a history of aortic valve dysfunction status post remote St. Jude valve placement, hypertension who presents with the abrupt onset of the sensation that he had a lid of a paint can that began in his epigastrium and slammed up into his jaw and then came down and continues to compresses upon his abdomen. It came on abruptly after he loaded the car. The patient does not believe he overexerted myself. He felt mildly diaphoretic and noted that his legs began to shake. He denied dyspnea. He did not pass out. He denies a history of AAA. The patient denies a history of coronary artery disease. The patient has persistent pain in his epigastrium. The patient did have a scant amount of diarrhea but does not believe that this is related to GI distress.

Dictated by: Steven Fisher.

KNOWN ALLERGIES
Iodinated contrast -- Anaphylaxis, Iodinated Radiocontrast Agents -- Entered brand: iodinated contrast -- anaphylaxis, Iodinated Radiocontrast Agents -- Entered brand: iodinated radiocontrast dyes -- undefined, Iodinated Radiocontrast Agents -- Entered brand: ivp dye -- undefined, Iodinated radiocontrast dyes, Ivp dye

CURRENT MEDICATIONS (11:45 LS)

Warfarin Sodium: mg ORAL Daily .
Multivitamin
**Complete per patient/outside source*
Metoprolol Tartrate: mg ORAL Every 12 hours .

PAST MEDICAL HISTORY (Wed Feb 22, 2012 11:45 LS)
MEDICAL HISTORY: **Hypertension, No past medical history, (No Documented Health Issues) No Documented Health Issues .**
SURGICAL HISTORY: **History of orthopedic, left, fibula x2 fx, History of valve replacement, mitral valve(st. Jude). aortic valve.**
PSYCHIATRIC HISTORY: **No history of anxiety, No history of bipolar, No history of depression.**
SOCIAL HISTORY: **Denies alcohol abuse, Denies tobacco abuse, Denies drug abuse.**
FAMILY HISTORY: **Family history includes hypertension.**

ROS (17:15 SF)
ROS TRANSCRIPTION: All systems were reviewed and negative except as stated in the patient's HPI.

Dictated by: Steven Fisher.

VITAL SIGNS
VITAL SIGNS: BP: 169/84, Pulse: 66, Resp: 18, Temp: 96.1 (PO), Time: 2/22/2012 11:42. (11:42 LS)
BP: 148/72, Pulse: 73, Resp: 18, O2 sat: 97 on RA, Time: 2/22/2012 12:37. (12:37 LS)
BP: 131/59, Pulse: 70, Resp: 18, O2 sat: 94 on RA, Time: 2/22/2012 12:59. (12:59 LS)
BP: 165/77, Pulse: 66, Resp: 17, O2 sat: 96 on RA, Time: 2/22/2012 15:26. (15:26 PB4)
BP: 160/70, Pulse: 80, Resp: 17, O2 sat: 96 on RA, Time: 2/22/2012 15:46. (15:46 PB4)

PHYSICAL EXAM (17:15 SF)
PHYSICAL EXAM TRANSCRIPTION: The patient is awake and alert. He does move all extremities spontaneous. He
a appears to be grossly neurologically intact, very kind and cooperative. Conjunctivae are not pale. Mucous membranes are moist. Neck: Supple. Lungs: Clear. Cardiac rate is regular. No murmurs or gallops but he does have a systolic click. Belly is very generously proportioned. It makes the examination difficult. The patient is tender in the epigastrium. I do feel an aortic pulsation which is concerning given this gentleman's proportions. He does not have any distension or tympany. No peritoneal signs. The patient's vascular examination in his lower extremities he is symmetrically diminished. His legs do appear to be warm and well–perfused. There is no mottling. He has preserved strength and sensation.

Dictated by: Steven Fisher.

DIFFERENTIAL DIAGNOSIS (17:15 SF)
DIFFERENTIAL DIAGNOSIS TRANSCRIPTION: 1. Epigastric pain of uncertain etiology. 2. Gastrointestinal distress.

3. Abdominal aortic aneurysm. 4. Renal colic. 5. Acute coronary syndrome. These and other diagnoses were considered.

Dictated by: Steven Fisher.

ORDERS

Comprehensive Metabolic Pnl by Fisher, MD, Steven for Fisher, MD, Steven on Wed Feb 22, 2012 12:24 Status: Done by System Wed Feb 22, 2012 13:13
PTT.. by Fisher, MD, Steven for Fisher, MD, Steven on Wed Feb 22, 2012 12:24 Status: Done by System Wed Feb 22, 2012 13:05
Infusor – Insert by Fisher, MD, Steven for Fisher, MD, Steven on Wed Feb 22, 2012 12:24 Status: Done by System Wed Feb 22, 2012 12:27
Protime.. by Fisher, MD, Steven for Fisher, MD, Steven on Wed Feb 22, 2012 12:24 Status: Done by System Wed Feb 22, 2012 13:02
CBC/Diff/Platelets by Fisher, MD, Steven for Fisher, MD, Steven on Wed Feb 22, 2012 12:24 Status: Done by System Wed Feb 22, 2012 13:08
EKG 12 Lead – Pain Abd by Fisher, MD, Steven for Fisher, MD, Steven on Wed Feb 22, 2012 12:24 Status: Done by System Wed Feb 22, 2012 12:27
Cardiac Troponin by Fisher, MD, Steven for Fisher, MD, Steven on Wed Feb 22, 2012 12:24 Status: Done by System Wed Feb 22, 2012 13:21
CK w/Reflexive MB by Fisher, MD, Steven for Fisher, MD, Steven on Wed Feb 22, 2012 12:24 Status: Done by System Wed Feb 22, 2012 13:13
CT Abd/Pelvis WITHOUT Contrast by Fisher, MD, Steven for Fisher, MD, Steven on Wed Feb 22, 2012 12:31 Status: Done by System Wed Feb 22, 2012 13:36
Urinalysis POC by Fisher, MD, Steven for Fisher, MD, Steven on Wed Feb 22, 2012 12:37 Status: Active
Physician Consult – OTHER by Majeski, AA, Jennifer for Fisher, MD, Steven on Wed Feb 22, 2012 13:59 Status: Done by System Wed Feb 22, 2012 14:00
Physician Consult – UNREFERRED by Majeski, AA, Jennifer for Fisher, MD, Steven on Wed Feb 22, 2012 14:08 Status: Done by System Wed Feb 22, 2012 14:08
Place Patient in Observation Status by Majeski, AA, Jennifer for Fisher, MD, Steven on Wed Feb 22, 2012 14:27 Status: Done by System Wed Feb 22, 2012 14:27
Nutrition–Doc to RN – Meds NSO by Turner, MD, Margo for Turner, MD, Margo on Wed Feb 22, 2012 15:56 Status: Active
Physician Group Consult Routine NSO by Turner, MD, Margo for Turner, MD, Margo on Wed Feb 22, 2012 15:57 Status: Active
O2 Therapy Cannula NSO by Turner, MD, Margo for Turner, MD, Margo on Wed Feb 22, 2012 16:01 Status: Active
Activity NSO by Turner, MD, Margo for Turner, MD, Margo on Wed Feb 22, 2012 16:01 Status: Active
Doc to Nurse by Turner, MD, Margo for Turner, MD, Margo on Wed Feb 22, 2012 16:01 Status: Active
Vital Signs NSO by Turner, MD, Margo for Turner, MD, Margo on Wed Feb 22, 2012 16:01 Status: Active
CK w/Reflexive MB NSO by Turner, MD, Margo for Turner, MD, Margo on Wed Feb 22, 2012 16:01 Status: Active
CK w/Reflexive MB NSO by Turner, MD, Margo for Turner, MD, Margo on Wed Feb 22, 2012 16:01 Status: Active

O2 Therapy Cannula NSO by Turner, MD, Margo for Turner, MD, Margo on Wed Feb 22, 2012 16:01 Status: Active
Notify H.O.–Signs/Symptoms NSO by Turner, MD, Margo for Turner, MD, Margo on Wed Feb 22, 2012 16:01 Status: Active
Diet – NPO by Turner, MD, Margo for Turner, MD, Margo on Wed Feb 22, 2012 16:01 Status: Active
O2 Therapy Cannula NSO by Turner, MD, Margo for Turner, MD, Margo on Wed Feb 22, 2012 16:01 Status: Active
Notify H.O.–Vital Signs NSO by Turner, MD, Margo for Turner, MD, Margo on Wed Feb 22, 2012 16:01 Status: Active
Diet – NPO by Turner, MD, Margo for Turner, MD, Margo on Wed Feb 22, 2012 16:01 Status: Cancelled by System Wed Feb 22, 2012 16:03
Telemetry Monitor NSO by Turner, MD, Margo for Turner, MD, Margo on Wed Feb 22, 2012 16:01 Status: Active
Cardiac Troponin NSO by Turner, MD, Margo for Turner, MD, Margo on Thu Feb 23, 2012 00:00 Status: Active
Cardiac Troponin NSO by Turner, MD, Margo for Turner, MD, Margo on Thu Feb 23, 2012 00:00 Status: Active
Comprehensive Metabolic Pnl NSO by Turner, MD, Margo for Turner, MD, Margo on Thu Feb 23, 2012 06:00 Status: Active
CBC/Diff/Platelets NSO by Turner, MD, Margo for Turner, MD, Margo on Thu Feb 23, 2012 06:00 Status: Active
Protime.. NSO by Turner, MD, Margo for Turner, MD, Margo on Thu Feb 23, 2012 06:00 Status: Active
EKG 12 Lead NSO by Turner, MD, Margo for Turner, MD, Margo on Thu Feb 23, 2012 07:00 Status: Active

MEDICATION ADMINISTRATION SUMMARY

Drug Name	Dose Ordered	Route	Status	Time
Zofran	8 mg	IntraVenous Push	Cancelled	14:53 2/22/2012
*Ondansetron Hydrochloride Novaplus	4 mg	IntraVenous Push	Held	16:04 2/22/2012
*Morphine Sulfate	2 mg	IntraVenous Push	Held	16:04 2/22/2012
*Sodium Chloride 0.9%, Intravenous	125 mL/hr	IntraVenous Continuous	Held	16:04 2/22/2012
*Morphine Sulfate	4 mg	IntraVenous Push	Given	15:38 2/22/2012
*Ondansetron Hydrochloride Novaplus	8 mg	IntraVenous Push	Held	15:26 2/22/2012
Morphine Sulfate	4 mg	IntraVenous Push	Given	13:40 2/22/2012

*Additional information available in notes, Detailed record available in Medication Service section.

MEDICATION SERVICE

Morphine Sulfate: Order: Morphine Sulfate : 4 Mg/Ml Solution – **Dose:** 4 mg :
IntraVenous Push
Ordered by: Steven Fisher, MD
Entered by: Steven Fisher, MD Wed Feb 22, 2012 12:37
Documented as given by: Lynne Stebulis, RN Wed Feb 22, 2012 13:40
Patient, Medication, Dose, Route and Time verified prior to administration.
, Amount given: 4 mg, IV SITE #1 IVP, initial medication, Slowly, Catheter placement confirmed via flush prior to administration, IV site without signs or symptoms of infiltration during medication administration, No swelling during administration, No drainage during administration, IV flushed after administration, Correct patient, time, route, dose and medication confirmed prior to administration,

Patient advised of actions and side–effects prior to administration, Allergies confirmed and medications reviewed prior to administration.

Morphine Sulfate: Order: Morphine Sulfate : 4 Mg/Ml Solution – **Dose:** 4 mg :
IntraVenous Push
Notes: per verbal order
Ordered by: Steven Fisher, MD
Entered by: Perry Benedict, RN Wed Feb 22, 2012 15:31
Documented as given by: Perry Benedict, RN Wed Feb 22, 2012 15:38
Patient, Medication, Dose, Route and Time verified prior to administration.
, Amount given: 4mg, IV SITE #1 IVP, repeat same medication, Slowly, Connections checked prior to administration, Line traced prior to administration, Catheter placement confirmed via flush prior to administration, IV site without signs or symptoms of infiltration during medication administration, No swelling during administration, No drainage during administration, IV flushed after administration, Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side–effects prior to administration, Allergies confirmed and medications reviewed prior to administration, Emotional support needed and given.

Morphine Sulfate: Order: Morphine Sulfate : 2 Mg/Ml Solution – **Dose:** 2 mg :
IntraVenous Push
Schedule: Due: Feb 22, 2012 15:59
Notes: EVERY 4 HOURS; PRN: PAIN; MORPHINE INJECTABLE
Ordered by: Margo Turner, MD
Entered by: Margo Turner, MD Wed Feb 22, 2012 16:04 ,
Held by: Margo Turner, MD Wed Feb 22, 2012 16:04 Reason: EVERY 4 HOURS; PRN: PAIN; MORPHINE INJECTABLE.

Ondansetron Hydrochloride Novaplus: Order: Ondansetron Hydrochloride Novaplus (Ondansetron Hydrochloride) : 2 Mg/Ml Solution – **Dose:** 8 mg : IntraVenous Push
Schedule: Due: Feb 22, 2012 14:49
Notes: ONCE; ONDANSETRON INJECTABLE; ADMIN: Push over 1 minute.
Ordered by: Steven Fisher, MD
Entered by: Steven Fisher, MD Wed Feb 22, 2012 14:53 ,
Held by: Perry Benedict, RN Wed Feb 22, 2012 15:26 Reason: Patient refused.

Ondansetron Hydrochloride Novaplus: Order: Ondansetron Hydrochloride Novaplus (Ondansetron Hydrochloride) : 2 Mg/Ml Solution – **Dose:** 4 mg : IntraVenous Push
Schedule: Due: Feb 22, 2012 15:58
Notes: Q4H; PRN: NAUSEA/VOMITING; ONDANSETRON INJECTABLE; ADMIN: Push over 1 minute.
Ordered by: Margo Turner, MD
Entered by: Margo Turner, MD Wed Feb 22, 2012 16:04 ,
Held by: Margo Turner, MD Wed Feb 22, 2012 16:04 Reason: Q4H; PRN: NAUSEA/VOMITING; ONDANSETRON INJECTABLE; ADMIN: Push over 1 minute.

Sodium Chloride 0.9%, Intravenous: Order: Sodium Chloride 0.9%, Intravenous (Sodium Chloride) : Sodium Chloride 0.9% Solution – **Dose:** 125 mL/hr : IntraVenous Continuous
Schedule: Due: Feb 22, 2012 15:57
Notes: SODIUM CHLORIDE 0.9% INFUSION; VOLUME: 1000 MILLILITER(S)
Ordered by: Margo Turner, MD
Entered by: Margo Turner, MD Wed Feb 22, 2012 16:04 ,
Held by: Margo Turner, MD Wed Feb 22, 2012 16:04 Reason: SODIUM CHLORIDE 0.9% INFUSION; VOLUME: 1000 MILLILITER(S).

ABINGTON MEMORIAL HOSPITAL
EMERGENCY DEPARTMENT

Strimber, Abraham
DOB: 11/14/1950 M61
Wt/Ht:
MedRec: 0482935
AcctNum: 1205350964

(CANCELLED) Zofran: Order: Zofran (Ondansetron Hydrochloride) : 2 Mg/Ml Solution –
Dose: 8 mg : IntraVenous Push
Ordered by: Steven Fisher, MD
Entered by: Steven Fisher, MD Wed Feb 22, 2012 14:42
Cancelled by: Steven Fisher, MD. Wed Feb 22, 2012 14:53
, Cancel reason: CLARIFICATION OF ORDER; ONCE; ONDANSETRON INJECTABLE; ADMIN: STAT(ETC).

RESULTS
RADIOLOGY: CT ABD PEL W O CONTRAST Wed Feb 22, 2012 13:35,

HISTORY: Mid upper abdominal and back pain.

TECHNIQUE: Helical axial images were obtained from the domes of the diaphragm through the pubic symphysis. Neither oral nor intravenous contrast was administered. Coronal and sagittal reformatted images were also evaluated.

Comparison: None.

FINDINGS:

The patient is status post median sternotomy. The heart is enlarged. There is no pericardial effusion. There is dependent atelectasis at the lung bases posteriorly.

Evaluation of the abdominal and pelvic organs is limited without intravenous contrast.

The liver is unremarkable without evidence of solid mass or biliary ductal dilatation. The gallbladder is unremarkable in appearance.

The spleen is normal in appearance. The pancreas is unremarkable. The right adrenal gland is unremarkable. There is a subcentimeter low–attenuation nodule in the left adrenal gland which likely represents an adenoma.

There are no abnormally enlarged mesenteric, retroperitoneal, pelvic, or inguinal lymph nodes.

There is a small fat containing left inguinal hernia. The prostate gland is unremarkable. The urinary bladder is normal in appearance without focal mass or wall thickening.

There is no bowel obstruction, bowel wall thickening, or free air. No free fluid is visualized. A normal appendix is visualized.

No hydronephrosis or renal calculus is seen. There is a cystic lesion

in the lower pole the left kidney, which is likely a simple cyst, however is incomplete characterized on this noncontrast examination. Repeat study with intravenous contrast and be helpful to better characterize the nature of this lesion.

There is minimal aortoiliac atherosclerosis. There is no aneurysmal dilatation or evidence of dissection or rupture on this noncontrast study.

There are mild scoliotic and degenerative changes of the spine. No destructive bony lesions are visualized.

Impression: Somewhat limited study without intravenous contrast.

Cystic lesion in the left kidney is likely a simple cyst , however it is incompletely characterized without intravenous contrast. Ultrasound of the kidneys or CT scan with intravenous contrast would be helpful to better determine the nature of this lesion.

No abdominal aortic aneurysm. No evidence of dissection on this noncontrast study.

Cardiomegaly.

Signed by: GOLDMAN, YEDIDA
Signed on: 02/22/2012 13:31:31

. (13:38 SF)

(13:27 SF)

Measurement	Result	Units	Range
CARDIAC TROPONIN I Wed Feb 22, 2012 12:42			
CARDIAC TROPONIN I	<0.10	ng/ml	
	WITHIN REFERENCE		
	INTERVAL		<0.10

(13:27 SF)

Measurement	Result	Units	Range
COMP METABOLIC PANEL Wed Feb 22, 2012 12:42			
GLUCOSE, RANDOM	141	MG/DL	70–110
BLOOD UREA NITROGEN	14	MG/DL	0–23
CREATININE	1.32	MG/DL	0.00–1.25
SODIUM	141	MEQ/L	135–145
POTASSIUM	3.7	MEQ/L	3.5–5.1
CHLORIDE	105	MEQ/L	98–110
CO2	23	MEQ/L	20–31
ANION GAP	17		9–18

ABINGTON MEMORIAL HOSPITAL
EMERGENCY DEPARTMENT

Strimber, Abraham
DOB: 11/14/1950 M61
Wt/Ht:
MedRec: 0482935
AcctNum: 1205350964

AST	26	U/L	5–34
ALT	18	U/L	0–55
ALK PHOSPHATASE	68	U/L	40–150
TOTAL BILIRUBIN	0.5	MG/DL	0.2–1.2
CALCIUM	8.9	MG/DL	8.5–10.7
ALBUMIN	4.3	GM/DL	3.4–4.8
TOTAL PROTEIN	6.6	GM/DL	5.8–7.6
CALC GFR–NON AFRICAN AMERICAN	55	mL/min/1.73m2	>60
GFR AFRICAN AMERICAN	>60	mL/min/1.73m2	>60
GFR COMMENT	The GFR estimate is		
	not adjusted for		
	extreme body surface		
	area. Nor has it		
	been		
	validated for		
	children less than		
	18 years, pregnant		
	women or ethnic		
	groups		
	other than		
	Caucasian and		
	African American.		

(13:27 SF)

Measurement	Result	Units	Range
CK Wed Feb 22, 2012 12:42			
CK	161	U/L	30–200

(13:27 SF)

Measurement	Result	Units	Range
AUTO BLD COUNT + DIFF Wed Feb 22, 2012 12:42			
WBC	12.1	K/UL	4.0–12.0
RBC	5.02	M/UL	4.60–6.20
HGB	15.0	G/DL	14.0–18.0
HCT	43.8	%	42–52
MCV	87.4	FL	80–94
MCH	29.9	PG	27.0–33.6
MCHC	34.2	%	32.0–36.0
RDW	12.7	%	11.5–15.0
PLT	192	K/UL	140–400
MPV	8.1	FL	7.4–10.4
NEUTROPHILS	80	%	
LYMPH	11	%	
MONO	8	%	
EOS	1	%	
BASO	0	%	
ABS NEUTROPHILS	9.7	K/UL	1.8–9.0
ABS LYMPH	1.3	K/UL	1.5–3.2
ABS MONO	1.0	K/UL	0.0–0.9
ABS EOS	0.1	K/UL	0.0–0.5
ABS BASO	0.0	K/UL	0.0–0.2
DIFF TYPE	AUTOMATED		

(13:27 SF)

Measurement	Result	Units	Range
PTT Wed Feb 22, 2012 12:42			
APTT	40	SEC	22–35
HEPARIN THERPTC RNG	66–97 SEC*		
FOOTNOTE	*EQUIVALENT TO		
	0.3–0.7 UNITS OF		
	HEPARIN PER ML BY		
	FACTOR Xa ASSAY		
	TECHNIQUE.		

(13:27 SF)

ABINGTON MEMORIAL HOSPITAL
EMERGENCY DEPARTMENT

Strimber, Abraham
DOB: 11/14/1950 M61
Wt/Ht:
MedRec: 0482935
AcctNum: 1205350964

Measurement	Result	Units	Range
PROTIME Wed Feb 22, 2012 12:42			
INTNATL NORM RATIO	2.8		

DIAGNOSTICS AND INTERPRETATIONS (17:15 SF)
DIAGNOSTIC–INTERPRETATION TRANSCRIPTION: The patient was saturating 97% on room air which is evidence of adequate oxygenation and not hypoxia. On the monitor, the patient remained in a first–degree block. The patient's laboratory values were reviewed by me. Please see electronic medical record. The patient's creatinine 1.32, INR of 2.8. CT of the abdomen, pelvis showed no evidence of AAA nor dissection. The patient has a cystic lesion over the left kidney of uncertain etiology. He also had noted cardiomegaly.

Dictated by: Steven Fisher.

EKG INTERPRETATION (12:23 SF)
12 LEAD EKG INTERPRETATION: 12 lead EKG interpreted by ED Physician, At: 12:23 PM, Compared with previous EKG, No previous EKG available, EKG shows **First–degree AV block, normal axis, T–wave inversions in aVL without prior for comparison.**

NURSING ASSESSMENT: COMPREHENSIVE
CONSTITUTIONAL: History obtained from patient, Patient is cooperative, alert and oriented x 3. Patient's skin is warm and dry, **Patient appears in pain distress.** (12:08 LS1)
SKIN: Patient denies pain to skin, Skin warm and dry. (12:08 LS1)
NEURO: GCS eye opening is 4, verbal response is 5, motor respone is 6 Total GCS=15, Pupils PERRL, Motor strength to all extremities are strong and equal, Patient denies paresthesias, No facial droop noted, Patient denies headache, nausea, vomiting. Patient's speech is clear and understandable. (12:08 LS1)
BACK: Patient complains of pain to **middle back**, Pain described as **aching, On a scale 0–10 patient rates pain as 6**, Duration of pain: **this morning.** (15:27 PB4)
RESPIRATORY/CHEST: No complaint of pain, Breath sounds clear bilaterally, No acute respiratory distress, No intercostal retractions, No supraclavicular retractions, Equal chest expansion, No nasal flaring, No cough, Able to speak in full sentences. (12:08 LS1)
CARDIOVASCULAR: Patient denies chest pain, No extremity edema noted, Positive peripheral pulses bilaterally, **Heart sounds regular.** (12:08 LS1)
ABDOMEN: nontender, Positive bowel sounds in all 4 quadrants, Patient denies vomiting, diarrhea, constipation, flank tenderness. No pulsatile masses noted to abdomen, **Abdominal pain is diffuse, Pain radiates to back, Abdomen is distended.** (12:08 LS1)
Patient denies nausea, **Abdominal pain is diffuse, On a scale 0–10 patient rates pain as 4.** (15:27 PB4)
nontender, Positive bowel sounds in all 4 quadrants, Patient denies vomiting, diarrhea, constipation, flank tenderness. No pulsatile masses noted to abdomen, **Abdominal pain is diffuse, Pain radiates to back, Abdomen is distended.** (15:40 LS1)
GENITOURINARY MALE: No complaint of pain, No discharge, No urinary complaints. (12:08 LS1)
FALL RISK: Total fall risk score is: 0. (12:08 LS1)
NOTES: **pt states he was walking up the driveway after loading things in the car felt "a rising**

metallic feeling like someone put a paint can in my stomach and the lid was rising up into my throat". Wife states pt became pale and clammy. Denies syncope. Pt had 2 episodes of diarrhea and +nausea. C/o abd distention and pain radiating to back. (12:08 LS1)

NURSING ASSESSMENT: NURSES NOTE (13:49 PB4)
TIME ASSESSED: **inital contact with patient, patient presents lying on right side, on cardiac monitor, speech clear rr non labored. patient states pain relief with after morphine, patient describes pain as being ' all over here' (rubbing abdomen) spouse at bedside, call bell with in reach.**

AA COMMUNICATIONS
PROCEDURE: PHYSICIAN NOTIFICATION, **dr singer**, responded at: 2;00 pm. (14:00 JM2)
PHYSICIAN NOTIFICATION, **ao**, responded at: 2:00 pm, reason: admission. (14:09 JM2)

NURSING PROCEDURE: CARDIAC MONITOR (12:08 LS1)
TIME: Patient placed on cardiac monitor, non–invasive blood pressure monitor, continuous pulse Oximetry. After procedure, patient tolerating monitoring.

NURSING PROCEDURE: COMMUNICATIONS
PROCEDURE: Hand–off Communication given at 1600, Hand–off Communication given to amber 3H, Provided opportunity to answer questions. (16:07 LS1)
escort called, they state patient is next to be picked up. (16:59 PB4)

NURSING PROCEDURE: EKG CHART (12:09 LS1)
TIME: EKG was performed at triage, 12 lead EKG Performed–left chest, After procedure, EKG for interpretation given to Dr. fisher.

NURSING PROCEDURE: IV (12:07 LS1)
TIME: in 1 attempt, IV established 20 gauge catheter inserted, into left Forearm, Flushed with 10 mL normal saline, Labs drawn at time of placement, Specimen labeled in the presence of the patient and sent to lab, No drainage noted at site, No redness, No tenderness, clear occulusive dressing applied.

NURSING PROCEDURE: TRANSPORT TO TESTS (12:52 LS1)
TIME: Patient transported to, CT scan, Patient transported via, cart, Patient accompanied by, nurse.

MEDICAL DECISION MAKING (17:15 SF)
MEDICAL DECISION MAKING TRANSCRIPTION: Importantly, the patient received multiple doses of morphine intravenously.
Additionally received some IV fluids. The patient's pain did feel better.
Then, the patient had the advent of vomiting. The exact precipitant of the patient's pain remained unclear. I was worried based upon his examination that he could have a AAA. This did not appear to be the case. The patient did not receive IV contrast as he has a significant allergy to IV dye. Ultimately, the patient was admitted given our uncertainty as to the patient's pain. He was

clearly uncomfortable. The patient's case was discussed at length with the hospitalist who admitted the patient..

Dictated by: Steven Fisher.

ATTENDING NOTES (16:07 SF)
NOTES: I have reviewed the current medications and all elements of the patient's history obtained by nursing staff. I have personally seen and examined this patient. I have fully participated in the care of this patient., Physician dictation number: **246830.**

DIAGNOSIS (14:09 SF)
FINAL: PRIMARY: **Chest pain [NOS]**, ADDITIONAL: **Epigastric pain.**

DISPOSITION
PATIENT: Disposition: A – OBSERVATION, Placement , Condition: Guarded . (14:09 SF)
Disposition: . (14:29 JM2)
Disposition: . (14:29 JM2)
Disposition: . (15:44 LRMI)
Disposition: . (16:09 LS1)
Remove from ER. (17:09 PB4)
NOTES: hospitalist –green team– tele obs. (14:09 SF)

PRESCRIPTION
No recorded prescriptions

IMAGING (12:56 JM2)
EKG: Image captured from scanner.

ADMIN
DIGITAL SIGNATURE: Fisher, MD, Steven. (Thu Feb 23, 2012 10:25 SF)
CHART FAX: JULIAN JAKOBOVITS 4105800773. (17:09 PB4)
PATIENT DATA CHANGE: A08 9000878090803310 by Interface. (11:49)
Primary Nurse changed from (none) to Lynne Stebulis, RN. (11:49 LS1)
Extender: Phone 7643. (12:19 LS1)
Attending changed from (none) to Steven Fisher, MD. (12:23 SF)
A04 3426565 by Interface, Middle Name: (none), Payment: 309, Zip code: 21208, Language: Z, Race: W, Phone number: 410–272–1616, Family Dr: Julian Jakobovits, Triage Transport: AT . (12:35)
Ins Verification: Completed – BC/KS OBS Eligible. (12:55 ADIN)
A08 3428273 by Interface, Middle Name: (none), Family DR: Julian Jakobovits . (14:28)
A08 3428284 by Interface, Middle Name: (none), Family DR: Julian Jakobovits . (14:28)
A08 3428285 by Interface, Middle Name: (none), Family DR: Julian Jakobovits . (14:28)
A08 3428293 by Interface, Middle Name: (none), Admitting: Green Dept Of Med, Family DR: Julian Jakobovits . (14:29)
A08 3428295 by Interface, Middle Name: (none), Family DR: Julian Jakobovits . (14:29)
Extender: Phone 7646. (15:56 PB4)
BEDBOARD ENTRY: Request Date/Time: Feb 22, 2012 14:29, Diagnosis: Chest pain [NOS],

Diagnosis 2: Epigastric pain, Diagnosis 3: (none), IP Area Request: Observation – Telemetry, Admitting Doctor: Green Dept Of Med, Is this an AO admission?: N/A – not an AO admission. (14:29 JM2)

Request Date/Time: Feb 22, 2012 14:29, Diagnosis: Chest pain [NOS], Diagnosis 2: Epigastric pain, Diagnosis 3: (none), IP Area Request: Observation – Telemetry, Admitting Doctor: Green Dept Of Med, Is this an AO admission?: N/A – not an AO admission. (14:29 JM2)

Request Date/Time: Feb 22, 2012 14:29, IP Area Request: Observation – Telemetry, Admit Area: 3 Highland (X–2310), Admitting Bed: 3H02–1, Bed Ready : Yes. (15:44 LRMI)

Request Date/Time: Feb 22, 2012 14:29, Report Called: Yes, IP Nurse called for report?: Yes, Report given to?: amber, Opportunity to answer questions?: Yes, Reason for delay after report given: escort. (16:09 LS1)

Key:
ADIN=Dinkins, AA, Adraia JM2=Majeski, AA, Jennifer LRMI=Malone–Kirby, RN, Lisa LS=Ischinger, RN, Lori LS1=Stebulis, RN, Lynne MT3=Turner, MD, Margo PB4=Benedict, RN, Perry SF=Fisher, MD, Steven